CITY OF SCOTTSDALE 2010/2011 BENEFITS ENROLLMENT/CHANGE FORM

☐ **New Enrollment** ☐ **Open Enrollment** ☐ **Change in Enrollment** ☐ **Dependent change** ☐ **Termination of Coverage**	**Qualifying Event:** _____ **Qualifying Event Date & Effective Date:** _____

FOR HUMAN RESOURCES USE ONLY _____ Original to Medical File _____ Copy to Payroll on: _____ COBRA Notice Sent _____	Received on:

Employee Last Name	First Name, MI	Employee ID Number
Date of Birth	Home Phone	Work Phone

MEDICAL

☐ **CITY OF SCOTTSDALE EPO**
Aetna Elect Choice (Open Access) (408)

☐ **CITY OF SCOTTSDALE High Level PPO**
Choice POS II (Open Access) (410)

☐ **CITY OF SCOTTSDALE Basic PPO**
Aetna Open Choice (418)

☐ **WAIVE MEDICAL**
If you are a full time employee, you must provide proof of other coverage

LEVEL OF COVERAGE

Is this a level of coverage change ☐ Yes ☐ No

☐ Employee
AND
☐ Spouse
☐ Domestic Partner *
☐ Child(ren)
☐ Domestic Partner's Child(ren)*

DENTAL

☐ **ASSURANT DENTAL *HMO** (425)
Dental Office ID#_____*

☐ **CITY OF SCOTTSDALE PPO DENTAL** (420)
Delta Dental of Arizona

☐ **NO DENTAL**

LEVEL OF COVERAGE

☐ Employee
AND
☐ Spouse
☐ Domestic Partner *
☐ Child(ren)
☐ Domestic Partner's Child(ren) *

* **Dental Office ID#** - The dental office you choose will be applicable for you and your dependents unless you specify a different dental office for your dependents in the dependent section of the back of this form.

SHORT TERM DISABILITY

WEEKLY BENEFIT (430)

☐ No Short Term Disability
☐ 50% / week (08)
☐ 70% / week (09)

(Short Term Disability Coverage cannot exceed 70% or $1,000 of your weekly salary.)

STD can only be elected or changed during open enrollment. If you did not opt to enroll in short term disability coverage during your initial eligibility period, but opt to elect STD coverage during a future open enrollment, you will be subject to a late enrollment penalty.

HEALTH CARE SPENDING ACCOUNT (455)

☐ NO

☐ YES Designate Annual Amount: **$**_____(Maximum $4,000 per calendar year, deduction is taken 24 pay periods per year.)

DEPENDENT CARE ASSISTANCE PLAN (460)

☐ NO

☐ YES Designate Annual Amount: **$**_____(Maximum $5,000 per calendar year, deduction is taken 26 pay periods per year.)

TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)

Spouse Name (Last, First MI)	Social Security Number	Date of Birth	Gender

Spouse is covered on the following plan(s):
☐ Medical ☐ Dental, if Assurant give dependent's dental office #:

Domestic Partner's Name* (Last, First MI)	Social Security Number	Date of Birth	Gender

Domestic Partner is covered on the following plan(s):
☐ Medical ☐ Dental, if Assurant give dependent's dental office #:

Dependent 1 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 1 is covered on the following plan(s):
☐ Medical ☐ Dental, if Assurant give dependent's dental office #:

Dependent 2 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 2 is covered on the following plan(s):
☐ Medical ☐ Dental, if Assurant give dependent's dental office #:

Dependent 3 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 3 is covered on the following plan(s):
☐ Medical ☐ Dental, if Assurant give dependent's dental office #::

Dependent 4 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 4 is covered on the following plan(s):
☐ Medical ☐ Dental, if Assurant give dependent's dental office #:

Additional dependents may be listed on a separate page.

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election during the year except in the event of a life change. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that both of the flexible spending accounts must be re-enrolled in each year. I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. I authorize the City of Scottsdale to obtain any medical records regarding claims for benefits by my covered dependent(s) or me under an insurance or health plan sponsored by the City. I further authorize my health care provider to furnish the City (or its representative) any medical information concerning any claim made by my covered dependent(s) or me. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

☒ Signature _____ Date _____

HR Signature_____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an employee to enroll a domestic partner for insurance coverage, both the employee and the domestic partner must complete the Domestic Partnership Affidavit. The affidavit must be approved by City of Scottsdale Human Resources prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the employee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the employee. City employees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any premiums and claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.